

**CONSENT FOR MEDICAL TREATMENT**

Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent(s), or legal guardian(s), of the child named on the front of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. This written authorization is granted only after a reasonable effort has been made to contact me (us).

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Date Parent's/Guardian's signature

Consent for Treatment endorsed by the Iowa Chapter of the American Academy of  
Emergency Physicians

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Insurance Provider: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_ (month/year)

Do you wear: Glasses \_\_\_\_\_yes \_\_\_\_\_no / Contacts \_\_\_\_\_yes \_\_\_\_\_no /  
Dentures \_\_\_\_\_yes \_\_\_\_\_no

List any known allergies, drug reactions, or other pertinent medical information.  
(Diabetes, seizures, history of head injury with unconsciousness or confusion,  
medications, etc.)

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Please note and date any new injury information here:

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